STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Chiropractic services are reimbursed from the same fee schedule based on 70 percent of Medicare as authorized by the Legislature.

Chiropractors' services for EPSDT recipients, if medically necessary, are reimbursed from the fee schedule based on 70 percent of Medicare as authorized by the Legislature.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

6d Other Practitioners' Services:

Nurse practitioner services. Reimbursement for nurse practitioner services shall be at 90% of the fee for reimbursement paid to licensed physicians under the statewide physician fee schedule for comparable services under comparable circumstances.

Nurse practitioner services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

Disease Management Services. The disease management services are reimbursed on a per encounter basis with an encounter averaging between fifteen and thirty minutes. The reimbursement is a flat fee established after reviewing Medicaid's physician fee schedule and reimbursement methodologies and fees of other states and third party payers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Orthotics and Prosthetics for children under age 21, if medically necessary, are reimbursed as follows:

A. The payment for purchase of Orthotics and Prosthetics is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.

B. The payment for repair of Orthotics and Prosthetics is the cost, not to exceed 50 percent of the purchase amount.

C. The payment for other individual consideration items must receive prior approval from the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Orthotics and Prosthetics Reimbursement and Coverage Criteria are applicable.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Home Health Care Services - Payment for home health services shall be on the basis of cost or charges, whichever is less, as determined under standards and principles applicable to Title XVIII, not to exceed in cost the prevailing cost of skilled nursing home services under Medicaid. Effective July 1, 1981, payment for Home Health Services is in accordance with the Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A" attached); however, under no circumstances will the cost of Home Health Services exceed the cost of skilled nursing home services per month under the Medicaid Program.

Home health care services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph and in Exhibit A of Attachment 4.19-B.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Private Duty Nursing Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service basis.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Clinic Services:

(a) Ambulatory Surgical Center Facility Services - Reimbursement for facility services in ambulatory surgical centers (ASC) is based on the principles described in Subpart C, 42 CFR Part 416, further modified by the Mississippi Medicaid Commission to be statewide rates at 80% of the group rates set by HCFA by publication in the Federal Register.

In no instance will payments for services exceed the upper limits of the reasonable cost as determined under Title XVIII. All requirement of 42 CFR 447 will be met in making payments.

(b) Birthing Center Services - Reimbursement for birthing center providers is based on a fee-for-service basis. To establish a fee for birthing centers services, the per diem of hospitals providing delivery services was added for monitoring. The total per diem rate was divided by the number of hospitals providing delivery services for the average per diem. The reimbursement to birthing centers for monitoring services is 80% of the average hospital per diem. To establish a fee for birthing centers for monitoring services prior to transfer to a hospital, the fee for monitoring services was divided by 24 for an hourly rate. This rate was multiplied by three to arrive at a fee for monitoring services prior to transfer to a hospital.

(c) Other Clinic Services - Reimbursement is for clinics as defined in Section 41-3-15(5) of the Mississippi code of 1972, as amended. Reimbursement is based on cost reports submitted by the provider. The rate will be determined by dividing total reasonable cost by total encounters but will not exceed the upper limits specified in 42 CFR 447.321 through 447.325. The established rate setting period is July 1 to June 30. An interim rate is paid until the end of the reporting period when there is a retrospective cost settlement. Actual reasonable costs reported on the cost report are divided by actual encounters by clinic type to determine the actual cost per encounter. Overpayments will be recouped from the provider, and underpayments will be paid to the provider.

Clinic services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Dental Services - Payment is from a statewide fixed fee schedule. Effective July 1, 1999, all fees will be increased to 160% of the amount of the reimbursement rate that was in effect on June 30, 1999.

Dental services for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Physical Therapy and Related Services

(a) Physical therapy is reimbursed based on an established fee schedule.

(b) Occupational therapy is reimbursed based on an established fee schedule.

(c) Services for speech, hearing and language disorders are reimbursed based on an established fee schedule.

(d) Reimbursement to the Department of Education for these services will not exceed their actual cost. Actual cost to be determined by cost reports submitted by the Department of Education.

(e) Physical therapy and related services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Prescribed Drugs

Medicaid pays for certain legend and non-legend drugs prescribed by doctors licensed to prescribe the drugs authorized under the Program and dispensed by a licensed pharmacist or licensed authorized physician in accordance with State and Federal Laws. Only those drugs listed in the Medicaid Drug Formulary and its supplements will be compensable. Exception: Special exceptions for use of non-covered drug items may be made in unusual circumstances when prior authorization is given by Medicaid.

1. Payment Methodology

A. Multiple-Source Drugs:

Reimbursement for covered multiple-source drugs in the Medicaid Program shall be limited to the lowest of:

(1) The Federally-mandated upper limits for certain multiple-source drugs as established and published by HCFA plus a reasonable dispensing fee;

(2) The Mississippi Estimated Acquisition Cost (M.E.A.C.) for the drug plus a reasonable dispensing fee; or

(3) The provider's usual and customary charge to the general public.

B. Other Drugs

Reimbursement for covered drugs other than the multiple-source drugs with HCFA upper limits shall not exceed the lower of:

(1) The Mississippi Estimated Acquisition Cost (M.E.A.C.) for the drug plus a reasonable dispensing fee; or

(2) The provider's usual and customary charge to the general public for the drug.

(3) Non-legend products or over-the-counter products that are listed on the Formulary are reimbursed at the lower of the Division's estimated shelf price or the charge to the general public for the drug. No dispensing fee is paid.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

2. Mississippi Estimated Acquisition Cost (MEAC)

MEAC is defined as the Division's best estimate of the actual purchase price generally and currently paid by providers for a drug, identified by NDC number, marketed or sold by a particular manufacturer or labeler. For the estimated actual purchase price, the Division will use the average wholesale price(AWP), less a per cent discount if applicable, that is utilized by the current entity contracted by the Division to provide drug information services, e.g.,First Data Bank, Medispan, etc. In no case shall the per cent discount subtracted from AWP be greater than ten (10) per cent.

3. Dispensing Fees

Dispensing fees are determined on the basis of surveys that are conducted periodically by the Division of Medicaid and take into account various pharmacy operational costs. Between surveys, the dispensing fee may be adjusted based on various factors (i.e., CPT, etc.,). The dispensing fee of $4.91 is paid to all types of pharmacists. A dispensing fee of $2.10 is paid to all dispensing physicians.

4. Physician Override

The Division of Medicaid shall allow for a physician override on innovator multiple-source drugs for which a specific upper limit has been established under 42 CFR 447.331 (c) if a physician certifies in his or her own handwriting that a specific drug is "medically" necessary. This override is accomplished by the physician writing "brand medically necessary" on the face of the prescription in his or her own handwriting.

5. Usual and Customary Charges

The provider's usual and customary charge is defined as the charge to the non-Medicaid patient. The state agency obtains the provider's usual and customary charge from the pharmacy invoice. The accuracy of the usual and customary charge is validated by the staff pharmacist in the field who conducts on-site audits. Audits of prescription files and usual and customary fee schedules will be the means by which compliance with this stipulation is assured.